DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-22

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
April 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY 02 $ 100,000
b. FFY 03 $ 100,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1A & B Page 2
Attachment 4.19B Pages 19, 20, 21, 22, 26, 27, 28, 28A 29, 30, 31, 31A & 31B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1A & B Page 2
Attachment 4.19B Pages 19, 20, 21, 22, 26, 27, 28, 29, 30, 31, 31A & 31B

10. SUBJECT OF AMENDMENT:

FQHC/RHC

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:

13. TYPED NAME: **Jackie Garner**

14. TITLE: **DIRECTOR**

15. DATE SUBMITTED

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62763-0001
ATTENTION: John Rupcich

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10/31/01

18. DATE APPROVED: 12/28/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
OCT 31 2001

FORM HCFA-179 (07-92) *Instructions on Back*

DMCH - IL/IN/OH

State ILLINOIS

~~2b. RURAL HEALTH CLINIC SERVICES AND OTHER AMBULATORY SERVICES FURNISHED BY A RURAL HEALTH CLINIC~~ Federally Qualified Health Center/Rural Health Center services and other Ambulatory Services furnished by the "Center"

Those core services for which the center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

a) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants.

b) Other services for which a separate encounter may be billed include dentist, visiting nurses and behavioral health services defined as clinical psychologist or clinical social worker services.

c) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

1. medical case management;
2. laboratory services;
3. occupational therapy;
4. patient transportation;
5. pharmacy services;
6. physical therapy;
7. podiatric services;
8. speech and hearing services;
9. x-ray services;
10. health education;
11. nutrition services;
12. optometric services.

d) A Center that adds behavioral health services, Visiting Nurses Services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.

e) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the service(s).

~~For dental services, eyeglasses, hearing aids, prescribed drugs, prosthetic devices and durable medical equipment, the all inclusive rate utilized for Medicare covered services in independent rural health clinics will not be applicable.~~

~~• Dental services~~
~~Require prior approval (also see item 10, this attachment).~~
~~• Eyeglasses~~
~~Prior approval required for tinting and contact lenses (also see item 12d, this attachment).~~
~~• Hearing aids~~
~~Prior approval required for binaural hearing aids only.~~
~~• Prescribed drugs~~
~~See item 12a, this attachment.~~
~~• Prosthetic devices~~
~~Prosthetic devices (other than dental and artificial eyes) are provided only upon written recommendation of a physician. Require prior approval.~~
~~• Durable medical equipment~~
~~Requires prior approval. Must be accompanied by a written recommendation of a physician (also see item 7c, this attachment).~~
~~• Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.~~

State ILLINOIS

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TN # 01-22 APPROVAL DATE DEC 21 2001 EFFECTIVE DATE 1-1-02

SUPERSEDES

TN # 91-12

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -OTHER TYPE OF CARE -BASIS FOR REIMBURSEMENT

07/98 f. Special Reimbursement Requirements for Services Provided in Hospital Emergency Room and Clinic Settings.

i. When emergency room services are provided to clients, the hospital is required to code any fee-for-service claims with the emergency room place of service.

07/98 g. Encounter rate clinic reimbursement

07/98 i. For encounter rate clinics providing comprehensive health care for women and infants or encounter rate clinics operated by a county with a population of over three million, payment shall be made at the lesser of:

07/98 A. $50.00 per encounter, or

07/98 B. The clinic charge to the general public.

07/98 ii. For all other encounter rate clinics, payment shall be made at the lesser of:

07/98 A. The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or

07/98 B. $50.00 per encounter; or

07/98 C. The clinic charge to the general public.

07/98 h. Psychiatric clinic reimbursement

Reimbursement shall be made under the federally qualified health center methodology if the clinic meets the criteria as an FQHC. Otherwise the clinic shall be reimbursed as an encounter rate clinic.

~~07/98 i. Transitional Payments for FQHCs and Certain Encounter Rate Clinics~~

~~i. Certain clinics will be eligible to receive monthly transitional payments for managing the health care needs of certain clients under their care beginning December 1996. Certain clinics will be~~

TN # 01-22 APPROVAL DATE 1 2002 EFFECTIVE DATE 01-01-02

Supersedes
TN # 98-14

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -OTHER TYPE OF CARE -BASIS FOR REIMBURSEMENT

~~07/98~~ ~~eligible to receive transitional payments for the month of December 1996, and monthly thereafter, under the conditions described in this subsection. To receive monthly transitional payments, clinics must:~~

~~A. be either:~~

~~1. a Federally Qualified Health Center, as defined in Attachment 4.19-B 2.a. or~~

~~2. an Encounter Rate Clinic, as defined in Attachment 3.1-A 2. b., that has provided comprehensive health services to Medicaid clients prior to December 1996;~~

~~B. have a signed transitional payment contract with the Department; and~~

~~C. have a contract with a Health Maintenance Organization (HMO) or Prepaid Health Plan (PHP) that has a contract to provide comprehensive health services, or, upon the implementation of MediPlan Plus, have a contract with a Managed Care Entity (MCE). The fee-for-service equivalent of the sum of such contract, and any transitional payment described in this Attachment, may not exceed the limits described in Attachment 4.19-B 1.g.1. or Attachment 4.19-B 2.a.iv.~~

~~ii. Transitional payments to a clinic will consist of a per member per month payment for any Illinois Medicaid client enrolled with an HMO or PHP or, upon the implementation of MediPlan Plus, an MCE, for whom the clinic was their assigned care provider on the last day of the month.~~

~~iii. For the first six months covered under a transitional payment contract, the Department will make transitional payments for any number of Medicaid clients enrolled with an HMO, PHP or MCCN and assigned to the qualifying clinic as their primary care site. Thereafter, qualified clinics will receive transitional payments for a given month only if the total number of Medicaid clients enrolled with an HMO, PHP or MCCN and assigned to the qualifying clinic, meets or exceeds the following threshold levels established in the qualifying clinic's transitional payment contract for that month:~~

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -OTHER TYPE OF CARE -BASIS FOR REIMBURSEMENT

~~A. For the seventh through twelfth month, such threshold shall equal twenty percent(20%) of the qualifying clinic's Medicaid patient base;~~

~~B. For the thirteenth through eighteenth month, such threshold shall equal thirty percent (30%) of the qualifying clinic's Medicaid patient base;~~

~~C. For the nineteenth through twenty-fourth month, such threshold shall equal forty percent (40%) of the qualifying clinic's Medicaid patient base;~~

~~D. For the twenty-fifth month through the term of the contract, such threshold shall equal fifty percent (50%) of the qualifying clinic's Medicaid patient base.~~

~~iv. The Medicaid patient base shall be a number mutually agreed to by the Department and the qualifying clinic and established in the transitional payment contract that equals the number of Medicaid clients registered as patients of the qualifying clinic as of November 1996.~~

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -OTHER TYPE OF CARE -BASIS FOR REIMBURSEMENT

~~v. Transition payments shall equal:~~

~~A. eight dollars ($8) per member per month for the first twelve (12) month period of the clinic's effective date of a contract with the Department;~~

~~B. six dollars ($6) per member per month for the second twelve (12) month period of the clinic's effective date of a contract with the Department;~~

~~C. two dollars ($2) per member per month for the third twelve (12) month period of the clinic's effective date of a contract with the Department.~~

~~vi. No clinic qualifying under this subsection shall receive transitional payments beyond the earlier of:~~

~~A. three years from the effective date of a clinic's signed contract, or~~

~~B. June 30, 2000.~~

ii. Pediatric Outpatient Adjustment Payments

07/98 Pediatric Outpatient Adjustment Payments shall be made to all eligible hospitals excluding county-owned hospitals and hospitals organized under the University of Illinois Hospital Act, as described in Section c.8. of Chapter II, for outpatient services occurring on or after July 1, 1998 ~~1997~~, in accordance with this Section.

i. To qualify for payments under this Section, a hospital must:

A. be a children's hospital, as defined in 89 Ill. Adm. Code Section c.3.of Chapter II and,

B. have a Pediatric Medicaid Outpatient Percentage greater than 80% during the Pediatric Outpatient Adjustment Base Period.

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

2. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

a. Definitions.

"Federally qualified health center" (FQHC) means a health care provider that receives a grant under Section 330 of the *Public Health Service Act* or be determined to meet the requirements for receiving such a grant by Health Resources and Services Administration.

"Rural health clinic" (RHC) means a health care provider that has been designated by the U.S. Public Health Service, or by the Governor and approved by the U.S. Public Health Service, in accordance with the *Rural Health Clinics Act* to be a RHC.

"Center," for the purposes of this section, means both a FQHC and a RHC.

"Behavioral Health Services," for the purposes of this section, means services provided by a licensed clinical psychologist or licensed clinical social worker.

"Visiting Nurse Services," for the purposes of this section, means services provided in a patient's home by a registered nurse or licensed practical nurse in a designated home health shortage area.

b. Reimbursement.

The Centers will be reimbursed under a prospective payment system (PPS), ~~in accordance with the provisions of section 1902(aa) of the *Social Security Act*~~, for 100 percent of the average of the costs that are reasonable and related to the cost of furnishing such services by the Center in accordance with the provisions of federal law (42 USC 1396a(aa)). Baseline payment rates will be determined individually for each enrolled Center. Once determined, the baseline payment rate will be adjusted annually using the Medicare Economic Index (MEI). Payment for services provided on or after January 1, 2001, shall be made using specific rates for each Center as specified herein. ~~efficient costs incurred by the Center. A baseline payment rate will be determined individually for each enrolled Center. Once determined, the baseline payment rates will be adjusted annually using the Medicare Economic Index (MEI).~~

Payment for services provided on or after January 1, 2001, shall be made using a specific ~~rate~~ rates for each Center as specified herein.

i. Baseline payment rates.

A. For each Center, the Department will calculate a baseline medical encounter rate and, for each Center that that is enrolled with the Department to provide ~~offers~~ Behavioral Health Services , Visiting Nurse Services or dental ~~services~~, the Department will calculate a baseline Behavioral Health Services , Visiting Nurse Service or dental encounter rate, using the methodology specified herein. The cost basis for the baseline rates shall be drawn from individual Center cost reports for Center fiscal years ending in 1999 and 2000 or, in the instance of a Center that did not operate during the entirety of those periods, cost reports that cover the portions of those periods during which the Center was in operation.

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

B. The baseline payment rate shall be based upon allowable costs, reported by the Center, that are determined by the Department to be reasonable and efficient. The method for determining allowable ~~direct~~ cost factors is similar to that used for Medicare (42 USC 1395g), with the following ~~There are two~~ significant differences: The Department's methodology shall: (1) ~~the Department's methodology~~ considers costs associated with services not covered under Medicare (*e.g.*, pharmacy, patient transportation, medical case management, health education, and nutritional counseling), and, (2) apply reasonable constraints on allowable ~~overhead~~ cost, as described in v below, and (3) apply reasonable constraints on the total cost per encounter.

C. The baseline payment rate for a Center shall be the average (arithmetic mean) of the annual reasonable costs per encounter, calculated separately for each the fiscal years for which cost report data must be submitted, using the methodology specified in D, E, F, and G for the medical encounter rate, ~~and E for the~~ dental encounter rate, Behavioral Health Services encounter rate and Visiting Nurse encounter rate respectively.

D. Annual reasonable cost per medical encounter.

1. The annual reasonable cost per medical encounter shall be the lesser of:

   — The annual cost per encounter, as calculated in D.4; or

   — The reasonable cost of providing a medical encounter, which shall be 105 percent of the statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

2 Core services component

The core services component is the sum of the following two components:

— The allowable direct cost per encounter, which is the quotient of the allowable direct cost, as defined in i.B, for core services divided by the greater of (1) the number of encounters reported by direct staff (e.g., staff specified in v.A and, for the determination of encounter payment rates effective prior to January 1, 2002, subparagraph v.C., or (2) the number of encounters resulting from the application of the minimum efficiency standard found in v.A and v.C, and

— The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

3. Supplemental services component.

The supplemental services component is the sum of the following two components:

— The allowable supplemental cost per encounter, which is the quotient of the cost of services, (e.g. pharmacy, patient transportation, medical case management, health education, nutritional counseling, and other non-core services.) excepting core services, ~~only~~ dental services, and, effective January 1, 2002, Behavioral Health Services and Visiting Nurses Services provided by the Center, divided by the greater of (1) the number of encounters reported by direct staff or (2) the number of encounters resulting from application of the minimum productivity standard found in v.A and v.C, and

— The allowable overhead cost per encounter, which is the product of the allowable supplemental cost per encounter multiplied by the Center's allowable overhead rate factor.

4. Annual cost per encounter.

The annual cost per medical ~~cost per~~ encounter is the sum of the core services component, as determined in D.2, and the supplemental services component, as determined in D.3.

E. Annual reasonable cost per dental encounter.

1. The annual reasonable cost per dental encounter shall be the lesser of:

— The annual cost per encounter, as calculated in E.2; or

— The reasonable cost of providing a dental encounter, which shall be 105 percent of the statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

2. Annual cost per encounter.

The annual cost per encounter is the sum of the following two components:

— The allowable direct cost per encounter, which is the quotient of the allowable direct dental cost, as defined in I.B, divided by the greater of (1) the number of encounters reported by direct dental staff, or (2) the number of encounters resulting from the application of the minimum efficiency standard found in v.B, and

— The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

F. Annual reasonable cost per Behavioral Health Services encounter.

Effective for services provided on or after January 1, 2002, a separate annual reasonable cost per Behavioral Health Service encounter shall be determined.

1. The annual reasonable cost per Behavioral Health Service encounters shall be the lesser of:

   — The annual cost per encounter, as calculated in F.2; or

   — The reasonable cost of providing a behavioral health encounter, which shall be 105 percent of the statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

2. Annual cost per encounter.

   The annual cost per encounter is the sum of the following two components:

   — The allowable direct cost per encounter, which is the quotient of the allowable direct cost for Behavioral Health Services, as defined in i.B, divided by the greater of (1) the number of encounters reported by direct behavioral health staff, or (2) the number of encounters resulting from the application of the minimum efficiency standard found in v.C, and

   — The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.Annual reasonable cost per Visiting Nurse Services encounter.

G. Effective for services provided on or after January 1, 2002, a separate annual reasonable cost per Visiting Nurse Services encounter shall be determined.

1. The annual reasonable cost per Visiting Nurses Service encounters shall be the lesser of:

   — The annual cost per encounter, as calculated in G.2; or

   — The reasonable cost of providing a Visiting Nurse encounter, which shall be 105 percent of the statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

2. Annual cost per encounter.

   The annual cost per encounter is the sum of the following two components:

   — The allowable direct cost per encounter, which is the quotient of the allowable direct cost for Visiting Nurse Services, as defined in i.B, divided by the greater of (1) the number of encounters reported by direct Visiting Nurse staff, or (2) the number of encounters resulting from the application of the minimum efficiency standard found in v.D, and

   — The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

G.H. For any individual eligible under the medical assistance programs ~~administered by the Department,~~ a Center may bill only one medical encounter, ~~and~~ one dental encounter, one behavioral health encounter and one Visiting Nurse encounter per day. A Center will be reimbursed for a service only if it has enrolled with the Department to provide that service.

I. Claims submitted to the Department must comply with the requirements in the applicable provider handbook and related provider notices and must identify all services provided during the encounter.

ii. Cost basis.

Each Center must annually complete a cost report, in a format specified by the Department, for the Center's fiscal year. Each FQHC must also annually submit a copy of financial statements audited by an independent Certified Public Accountant. The cost report and audited financial statements must be filed with the Department within 180 days of the close of the Center's fiscal year, except for cost reports and audited financial statements for Center fiscal years 1999 and 2000 which, in the case of FQHCs must be filed with the Department no later than November 30, 2001, and in the case of RHCs, must be filed no later than March 30, 2002. Except for the first year during which the Center begins operations, the cost report must cover a full fiscal year ending on June 30 or other fiscal year which has been approved by the Department. Payments will be withheld from any Center which has not submitted the cost report by the applicable filing ~~deadline~~ date and no payment will be made, until such time as the reports or audited statements are received and approved by the Department.

iii. Establishment of initial year payment amount for a new Center.

For any Center that begins operation on or after January 1, 2001, the payment rate per encounter shall be the median of the payment rates per encounter of neighboring FQHCs or RHCs, as the case may be, with similar caseloads as determined by the Department. If the Department determines that there are no such comparable Centers, then the rate per encounter shall be the median of the payment rates per encounter for all FQHCs or RHCs, as the case may be, statewide.

iv. Rate adjustments.

A. Initial rate determinations

1. On or about January 1, 2002, the Department shall determine the medical, and dental encounter rates for each participating FQHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected FQHC.

2. On or before January 1, 2003, the Department shall determine the medical, and dental encounter rates for each participating RHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected RHC.

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

B. Annual adjustment

1. Beginning January 1, 2002, and annually thereafter, except as specified in B.2., the Department will adjust baseline rates by the most recently available MEI. The adjusted rates shall be paid for services provided on or after the date of the adjustment.

2. Except, in the instance of a Center which provided Behavioral Health or Visiting Nurse Services prior to January 1, 2002, for the purpose of applying the January 1, 2002, adjustment by the most recently available MEI, the baseline medical services encounter rate applicable for services provided from January 1, 2001, through December 31, 2001, shall be redetermined after removal of costs and encounters attributable to Behavioral Health Services.

C. Scope of service adjustment.

If a Center significantly changes its scope of services, the Center may request that a new baseline encounter rate be determined. Adjustments to encounter rates will be made only if the change in the scope of services results in the inclusion of Behavioral Health Services, Visiting Nurse Services, or dental services or a difference of at least five percent from the Center's current rate. The Department may initiate a rate adjustment, based on audited financial statements ~~and~~ or cost reports, if the scope of services has been modified to include Behavioral Health Services, Visiting Nurse Services or dental services or in a way that would result in a change of at least five percent from the Center's current rate.

v. Reasonable cost considerations.

The following minimum efficiency standards will be applied to determine reasonable cost:

A. Medical direct care productivity.

The Center must average 4,200 encounters annually per full-time equivalent (FTE) for physicians and 2,100 encounters per FTE for mid-level health care staff (*i.e.*, physician assistants, nurse practitioners, specialized nurse practitioners, and nurse midwives).

B. Dental direct care productivity.

The ~~FQHC~~ Center must average 1.5 encounters per hour per FTE for dentists.

C. Behavioral Health Service direct care productivity.

The Center must average 2,100 annual encounters per FTE for licensed clinical psychologists and licensed clinical social workers.

D. Visiting Nurse Service direct care productivity.

The Center must average 2,100 annual encounters per FTE for licensed practical or registered nurses providing Visiting Nurse Services

~~C.~~E. Guideline for non-physician health care staff.

The maximum ratio of staff is four ~~full-time equivalent~~ FTE non-physician health care staff for each FTE staff subject to the direct care productivity standards in A and B above.

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

~~D~~F. Allowable overhead.

The maximum Medicaid allowable overhead cost is 35 percent of allowable ~~direct~~ total cost.

vi. Adjustments for medical services paid for by a ~~health maintenance~~ managed care rganization (MCO)

The Department shall make payment adjustments to a Center if it provides care through a contractual arrangement with a Medicaid ~~Managed Care Organization (MCO)~~ and is reimbursed an amount, reported to the Department, that is less than the minimum payment required in 42 *U.S.C.* 1396a(aa). The amount of any such payment adjustments shall be at a fixed annual rate as determined by the Department. ~~All such services must be defined in a contract with an MCO. Such contracts must be made available to the Department.~~ For each Center so eligible, a payment adjustment shall take into consideration the total payments made by the MCO to the Center (including all payments made on a service-by-service, encounter, or capitation basis) ~~and any transitional payments made by the Department as defined in Attachment 4.19-B, Page 1.E.~~ In the event that Center cost data related to MCO services are unavailable to the Department, an estimate of such costs may be used that takes into consideration other relevant data. Adjustments will be made, ~~no less often than~~ at least quarterly, only for Medicaid eligible services ~~as defined in this State Plan~~. All such services must be defined in a contract between the Center and ~~with an~~ MCO. Such contracts must be made available to the Department.

vii. Audits.

All cost reports will be audited by the Department. The center will be advised of any adjustment resulting from these audits.

viii. Alternate payment methodology ~~for government-operated Centers.~~

A. For government-operated Centers.

A Center operated by a State or local government agency may elect to be reimbursed under the alternate payment methodology described in this subsection viii.

~~A.~~1. The State or local government agency shall enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to services provided by the Center and the funding thereof.

~~B.~~2. The Center operated by a State or local government agency shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections i through vii of this section.

~~C.~~3. The State or local government agency shall certify the expenditure of public funds in excess of reimbursement received from the Department, under paragraph B, and any reimbursement from other payers (*e.g.*, an insurance company, a managed care organization) for services provided to individuals eligible for medical assistance programs administered by the Department, provided the funds were not derived from a federal funding source or were not otherwise used as a State or local match for federal funds. The certification shall be in a form and format specified by the Department. The certification shall be filed within 30 days after the submission of the annual cost report. The certification shall compare expenditures within that cost reporting period to payments received/receivable for that same period.

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

~~D.~~4. The certified expenditures shall be used by the Department to claim federal financial participation. Federal funds resulting from the claiming of the certified expenditures shall be distributed, in accordance ~~ing~~ to the provisions of the agreement referenced in paragraph ~~A~~ 1, to the State or the government agency that operates the Center that provided the services.

B. Certain qualifying Centers

1. No later than 30 days after the initial rate determination specified in iv.A, the Department shall determine the eligibility of each Center for this alternative payment methodology. A Center will qualify for this alternative payment methodology if the Department's estimate of the total amount to be paid to the Center for services provided during the twelve-month period ending December 31, 2001, under the reimbursement policy and rates in effect prior to the initial rate determination, is greater than the total amount that will be paid for those same services under the initial rates. The Department shall notify each qualifying Center, in writing, of the result of this determination.

2. A qualifying Center may, for services provided from January 1, 2002, through December 31, 2002, elect to be reimbursed under the alternate payment methodology described in this subsection. A qualifying Center must notify the Department in writing, no later than 30 days following the date of the written notification from the Department, as its election to be reimbursed under this alternative payment methodology.

3. A Center electing this alternative payment system shall be reimbursed by the Department on a per encounter basis according to the provisions A through K, except the medical encounter payment rate shall be increased by an amount equal to twice the quotient resulting from the Department's estimate of the difference between (1) the total amount to be paid to the center for services provided during the twelve-month period ending December 31, 2001, under the initial rates as determined in iv.A and B and (2) the total amount that would have been paid under the payment rates in effect prior to the initial rate determination, divided by the Department's estimate of total medical encounters during the twelve-month period ending December 31, 2001.

4. Centers that are certified by the Department of Human Services, Office of Mental Health, or the Department of Children and Family Services to provide Behavioral Health Services may elect an alternate payment methodology for their Behavioral Health Services. An election of this alternate payment methodology will allow the Centers to be reimbursed under the provisions of 4.19-B # 21 - Rehabilitative Services. A qualifying Center must notify the Department, in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternative payment methodology.

viii. Multiple service sites operated by a Center.

All service sites operated by a Center shall be reimbursed using the Center's established encounter rates, except in the instance where the sites had submitted separate cost reports for fiscal years ending in 1999 and 2000 and separate baseline rates were determined for the site

State ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

ix. Appeals.

A. All Appeals of audit adjustments or rate determinations must be submitted in writing to the Department. All aAppeals must be submitted within ~~30~~ 60 calendar days ~~of rate~~ after the notification of such adjustment or rate determination ~~shall, if~~ If upheld, the revised audit adjustment or rate determination shall be made effective as of the beginning of the rate ~~year~~ period. ~~The effective date of all other upheld appeals shall be the first day of the month following the date the complete appeal was submitted. The Department shall rule on all appeals within 120 days of the date of the appeal except that, if the Department requires additional information from the Center, the period shall be extended until such time as the information is provided. Appeals for any rate year must be filed before the close of the rate year.~~

B. To be accepted for review, the written appeal shall include the following: (1) the current approved reimbursement rate, allowable costs, and the additional reimbursable costs sought through the appeal; (2) a clear, concise statement of the basis for the appeal; (3) a detailed statement of financial, statistical, and related information in support of the appeal, indicating the relationship between the additional reimbursable costs as submitted and the circumstances creating the need for increased reimbursement; and, (4) a statement by the Center's chief executive officer or financial officer that the application of the rate appeal and information contained in the ~~vendor~~ Center's reports, schedules, budgets, books and records submitted are true and accurate